Arizona Department of Health Services Office for Children with Special Health Care Needs Children's Rehabilitative Services Administration	**Effective Date: 03/01/2007** **Last Review Effective Date: 02/13/2008**
SUBJECT: Medical and Utilization Management	SECTION: MM/UM 1.5

SUBTITLE: Prior Authorization Review

POLICY:

It is the policy of the Children's Rehabilitative Services Administration (CRSA) to monitor all services delegated to the Children's Rehabilitative Services (CRS) Contractors including the prior authorization of services.

PROCEDURE:

1) CRSA Medical Management (MM)/Utilization Management (UM) staff conducts periodic CRS Contractor site visits to review the CRS Contractors' prior authorization services as follows:
   a) Prior authorization process review:
      i) Review and evaluate CRS Contractors' existing prior authorization process against a standard tool specifically designed for that purpose (See Attachment 1);
      ii) CRS Contractors are expected to receive a minimum performance score of 75 percent with a goal of 90 percent;
      iii) Review Provider Services Requisition (PSR) for all required elements (See Attachment 2); and
      iv) CRSA MM/UM staff confirms that all denials for prior authorizations are reviewed and signed by the CRS Medical Director.
   b) Chart Audits
      i) Chart audits are performed on a randomly selected sample of charts to review the application of the prior authorization process.
      ii) Timelines for the standard and expedited review are strictly monitored;
      iii) Elements reviewed are identified in the CRS Contractors Policy and Procedure Manual Chapter 11.0.

2) Prior authorization of services are also monitored and reviewed during the annual administrative review.

3) All redirected services to the Arizona Health Care Cost Containment System (AHCCCS) Health Plans and Third-Party Payers are reviewed biweekly for appropriate determination of non-CRS coverage by MM/UM Clinical Staff and the CRS Medical Director. Notices of Extension (NOE) are reviewed for appropriateness of need for extension. Any potential issues and concerns are presented in MM/UM Denial Subcommittee.

4) CRSA staff analyzes areas of concern related to prior authorizations.

5) CRSA staff reports findings and concerns to the CRSA MM/UM Committee.

6) The CRSA MM/UM Committee identifies areas requiring interventions.

7) CRS Contractors are asked to provide a response. If needed, a corrective action plan (CAP) is initiated and monitored until desired outcomes are achieved.

9) Findings are presented to the CRSA Executive Management Committee.

Approved:	Date:
Joan K Gyatt CRSA Administrator	2/18/08
Marcee + M.D. CRSA Medical Director	2/19/08

CRS Process Monitoring Tool
Prior Authorization

REVIEWERS' NAME: 1. 2.	CRS Site:	REVIEW DATE:

Prior Authorization- Required Process Elements	Maximum Itemized Score	Earned Score	
		Number	Percent
1. Contractor shall have a process for Prior Authorization:	**100**		
A. CRS Regional Contractor shall ensure that that there are adequate, qualified, professional medical staff to conduct prior authorization (a physician, physician assistant, nurse practitioner and/or a RN/BSN) with appropriate training to apply CRS medical criteria or make medical decisions.	20		
B. Written policy and procedure for prior authorization shall include following elements:	**80**		
✓ Process to authorize services in a sufficient amount, duration, or scope, such as timelines for the standard and expedited review process: 14 calendar days for Standard Request vs. 3 working days for expedited request; with an extension option of 14 days for both. Timelines shall be met even if the member has other third party liability insurance. A process for sending a letter for extension (if applicable).	50		
✓ Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.	20		
✓ Consultation with the requesting provider when appropriate.	10		
2. Have a system for approval and denial of services, e.g., Provider Service Requisition (PSR) "Provider Service Requisition Form Required Elements see separate scores from PSR review	**200**		
A. Shall have a procedure for denial of services that requires a clinical review by the CRS Regional Medical Director of decisions to deny authorization on the grounds of medical appropriateness, medical necessity, or CRS coverage.	25		
B. The Regional Medical Director shall consult with another appropriately credentialed CRS physician(s) for a second opinion regarding the requested procedure, if the requesting physician challenges the denial.	10		
C. Shall notify requesting provider of any decision to deny, limit, or discontinue authorization of services, and advise of appropriate steps to take for appealing the decision.	20		
D. Documentation regarding the reasons behind the adverse decision.	20		
E. Notification of the authorizations to the requesting providers	25		

CRS Process Monitoring Tool
Prior Authorization

REVIEWERS' NAME: 1. 2.	CRS Site:	REVIEW DATE:

Prior Authorization- Required Process Elements	Maximum Itemized Score	Earned Score	
		Number	Percent
upon completion			
F. Regional Contractor shall have documentation of services requiring prior authorization.	50		
G. Responsibility for obtaining prior authorization is with the providers. Provider and/or physician shall complete a Provider Services Requisition (PSR) form and send it to the Contractor Site where the service is to be provided.	20		
H. Shall maintain files in a secured location	15		
I. Shall document the decision process for each service request.	15		
OVERALL SCORE	**300**		

NOTE: Key to measure performance scores for Provider Services Requisition Required Elements (Scores will be based on the average score gained on PSR on-site reviews- see Provider Service Requisition Form Required Element Checklist).

References:

1) AHCCCS Medical Policy and Procedure Manual 1020 – C
2) Contract # HP 361008 Tasks 30 & 32
3) CRS Policy and Procedure Manual 80.401

Site _____CRS ID# _____Reviewer _____ Date of Review _____
Mo of PSR _____

Provider Service Requisition Form Required Elements Checklist

Crosswalk these elements to your PSR form to assure all elements are addressed

The CRS Provider Services Requisition (PSR) form shall contain the following demographic information: (Possible Score 100)

☐ CRS member name* ☐ Date of Birth* ☐ Address ☐ Phone
☐ Requesting physician/provider name** ☐ Address ☐ Phone ☐ Specialty**
☐ Requesting physician's Arizona medical license number**
☐ Signature of requesting physician or provider*** ☐ Date *
☐ POS (Facility/provider/physician)** ☐ Address ☐ Phone
☐ CRS Diagnosis*** ☐ Procedure(s) if applicable
☐ Supporting documents/reason for the service/medical necessity***

Documentation of: (Total Score = 150 points)

☐ RN Reviewer Name **
☐ Date Received by the CRS Regional Contractor***
☐ Date PSR Requested
☐ Type of Authorization Request: *** ☐ Standard ☐ Expedited
☐ CRS eligibility checked*
☐ Service covered by CRS*
☐ Third Party Liability insurance checked
☐ Type of Service* (in pt, office, ambulatory surgery etc)
☐ Was an extension requested? ☐ If Yes, reason given ☐ Extension letter sent
☐ Date of Prior Authorization Approval**
☐ Signature of authorizing medical professional (RN, BSN)**
☐ Notice sent to provider/physician/facility**
☐ By Staff person's name*
☐ Met timelines****
  ☐ Standard (14 calendar days)
  ☐ Expedited (3 working days)
  ☐ Extension (additional 14 calendar days-final decision within 28 calendar days)

If PA denied (50)

☐ Reason for denial***
☐ Signature of Medical Director*** ☐ Date *
☐ NOA or Non Coverage by CRS sent ***
  ☐ Notification to physician/provider/facility
  ☐ AHCCCS (if appropriate)

Key to Measure performance Scores

*	Every check in the box scores 5 points ___ no mark = 0 points
**	Every check in the box scores 10 points ___ no mark = 0 points
***	Every check in the box scores 15 points ___ no mark = 0 points
****	Every check in the box scores 60 points ___ no mark = 0 points

FY 08